CPAs & BUSINESS ADVISORS

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ACO'S SUCCESS AND IMPACTS ON FINANCE AND REVENUE CYCLE

CONTEXT

Increasing number of critical access hospitals and other rural providers have joined rural Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs)

Learning more about the future of population health

Developing the structures and programming necessary

- Improve coordination
- Improve quality
- Reduce cost

CONTEXT

Early results

- Opportunities to reduce cost
- Opportunities to improve quality
- Opportunities to increase patient satisfaction
- Opportunities to increase market share
- Roadblocks and challenges

Competing incentive programs

BACKGROUND

150+ facilities across the country are involved

Some are now in their third year of experience

Over **20 ACOs**

5,000 minimum beneficiary attrition

54 different facilities in **15 states** which are part of 12 different ACOs

More facilities were added in 2017 and 2018

Many providers are discussing strategies for 2019

WHAT HAVE WE LEARNED?

The game has changed
- Cannot be avoided in the long run
- Small providers can play the game

Changes in health care policy will not significantly change the direction of the course

Changes impact the revenue cycle

There will be winners – there will be losers

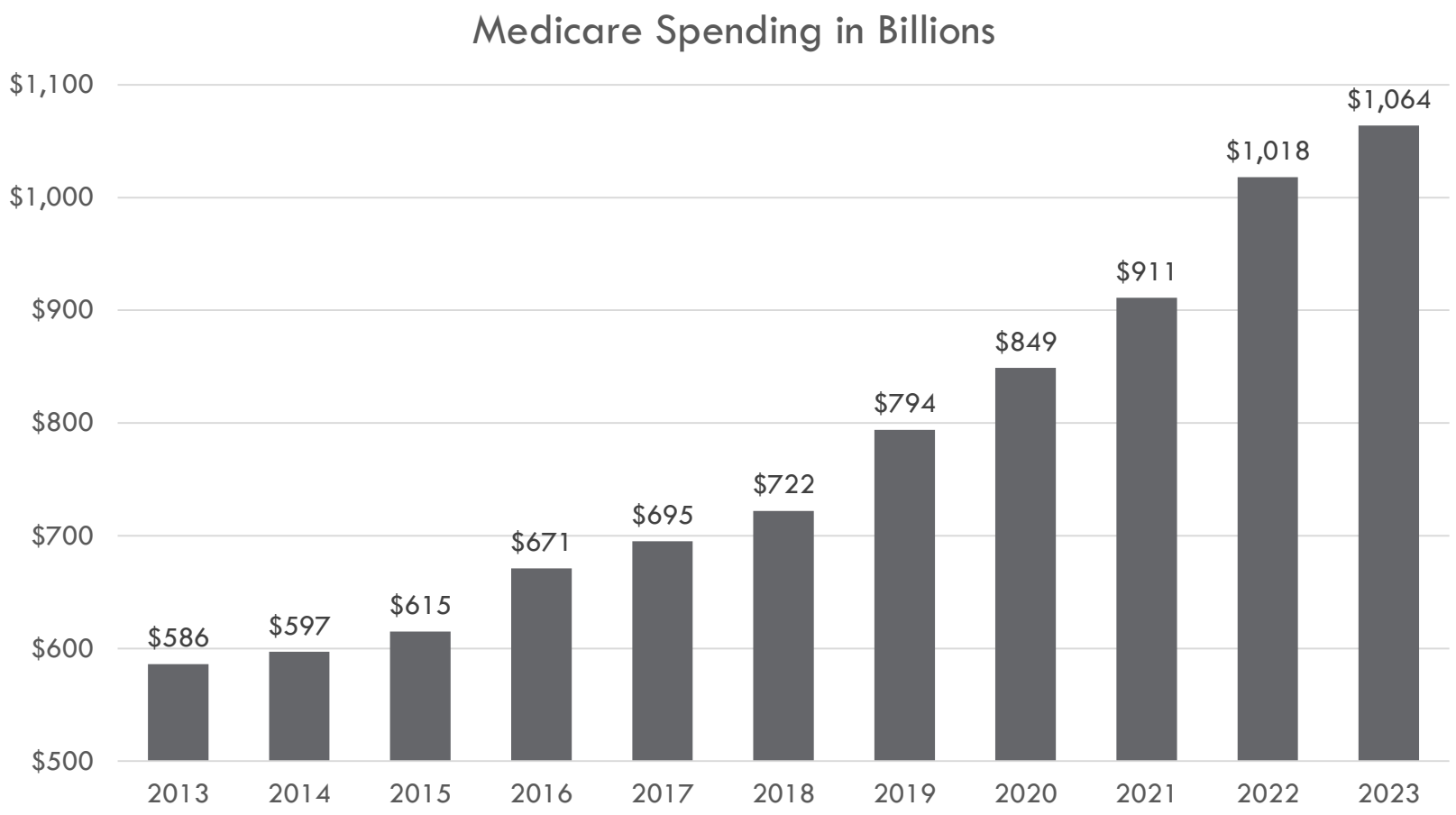
Changes are required

THE GAME HAS CHANGED – CHANGE IN POLICY WILL NOT CHANGE DIRECTION

Population health will occur as payors and patients will require the results

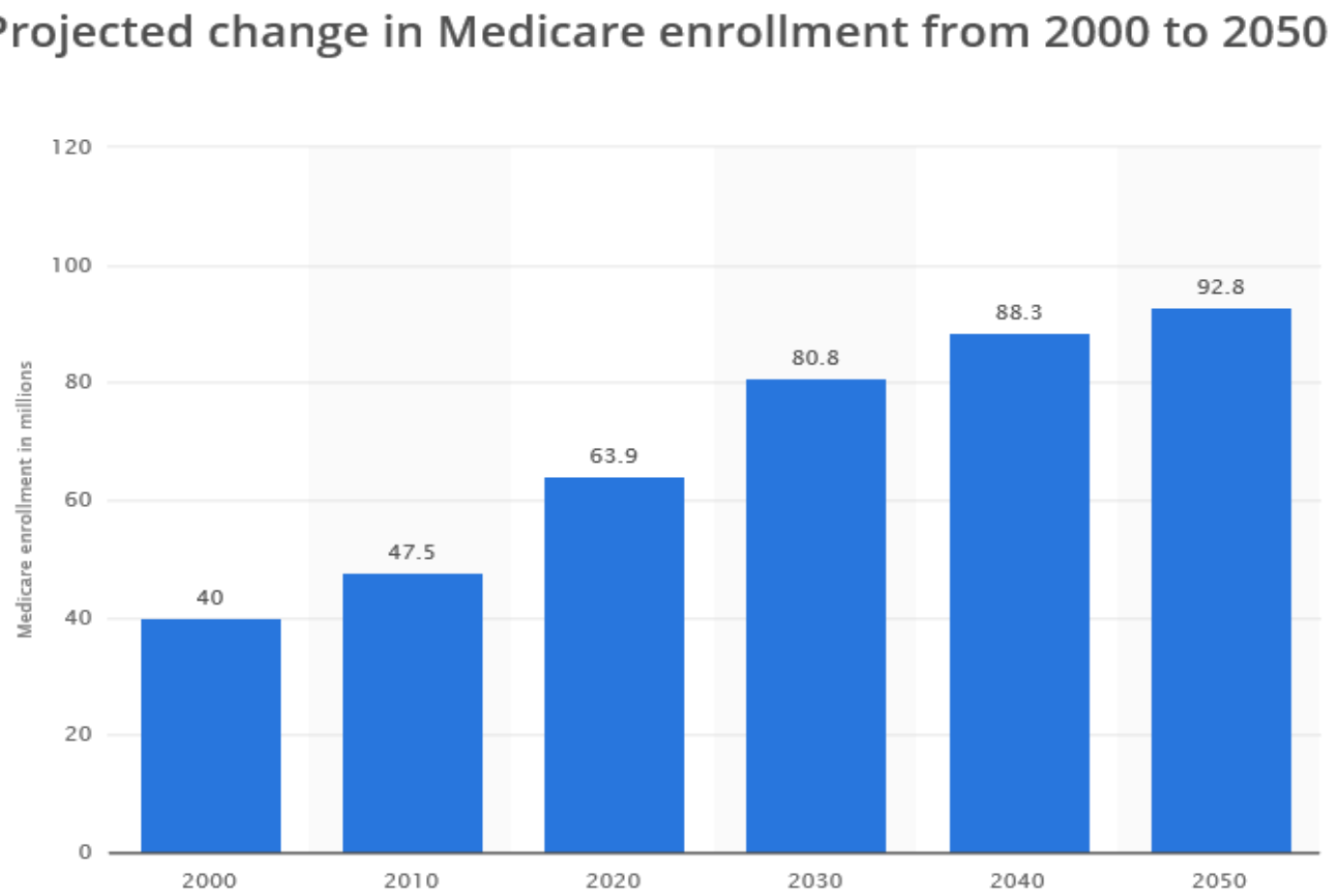
- Lower cost
  - Does not equate to rationing
  - Can be done while improving quality
- Higher quality
  - Demonstrable results

PROJECTED MEDICARE SPENDING, 2013-2023



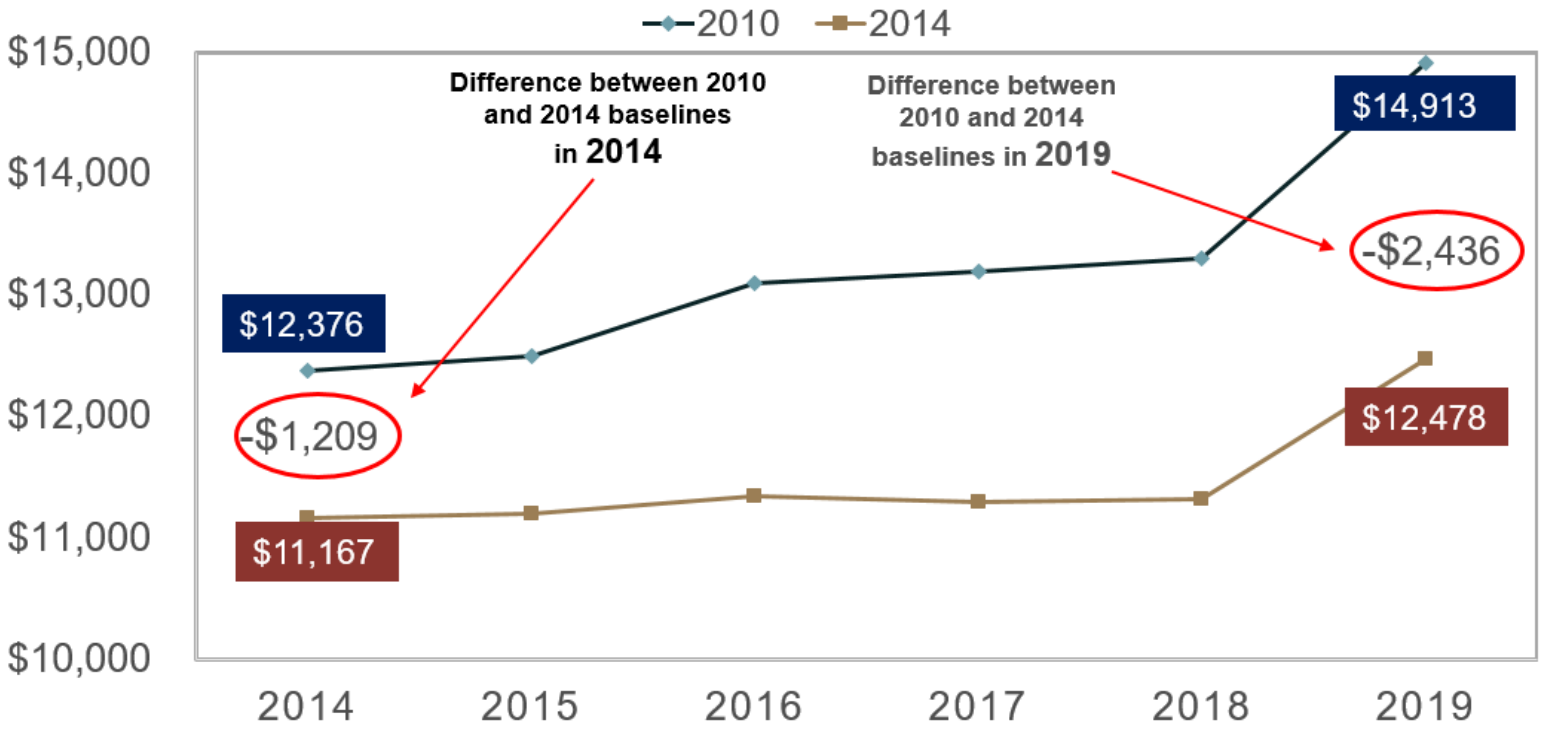
Source: Caravan Health

MEDICARE BENEFICIARY GROWTH



Source: statista – The Statistics Portal

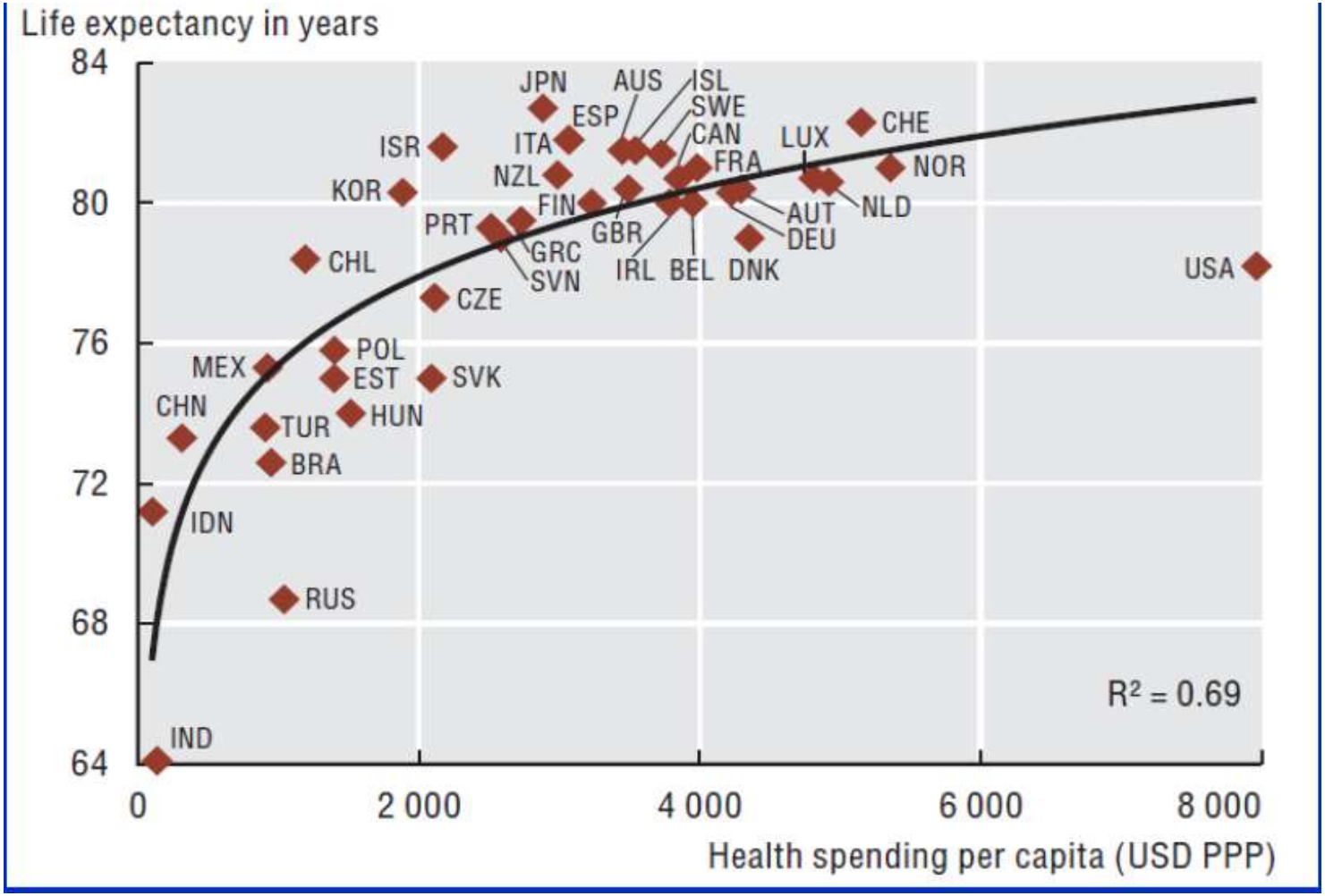
MEDICARE SPENDING WAS $1,200 LOWER PER BENEFICIARY IN 2014 THAN WAS PROJECTED IN 2010, AND $2,400 LOWER IN 2019



Source: Kaiser Family Foundation analysis of mandatory Medicare outlays and Medicare enrollment data from CBO Medicare baseline projections, 2010-2014; 2014 estimates based on August 2014 baseline.

Source: Caravan Health

LIFE EXPECTANCY



Source: OECD (2011), Health at a Glance 2011: OECD Indicators, OECD Publishing.

LIFE EXPECTANCY IN UNITED STATES

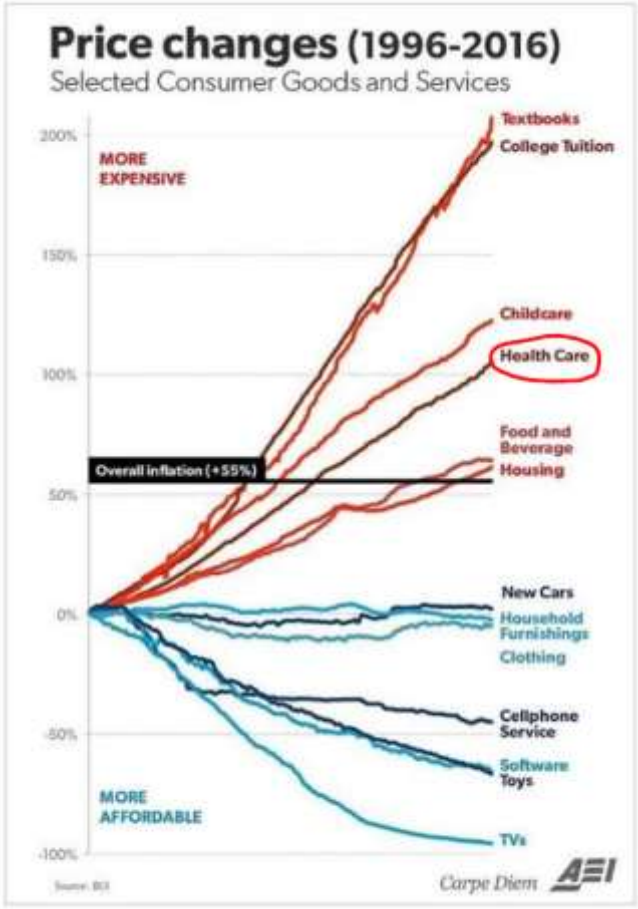
CNN

US life expectancy drops for second year in a row

December 21, 2017

- Two years in a row
- Last time a multiyear drop – 1962 and 1963
- U.S. overall dropped from 78.7 to 78.6 years
- U.S. males dropped from 76.3 to 76.1 years
- U.S. females stable at 81.1 years

PRICE CHANGES



Mark Perry/American Enterprise Institute

"The stuff we really need is getting more expensive. Other stuff is getting cheaper."

Sources: The Washington Post, Wonkblog August 17, 2016

THERE WILL BE WINNERS – THERE WILL BE LOSERS

"Ostriches" will not be rewarded

Early adopters will have the advantage

- More forgiveness
- Slower learning curve

CHANGES ARE REQUIRED

Same processes = same results

Success is not guaranteed

MAKING THE DECISION TO JOIN AN ACO

It takes commitment – lip service does not cut it

Who has to be committed? – Three-legged stool

- Groups
  - Board
  - C-suite
  - Provider leadership

- A two-legged stool does not stand

MAKING THE DECISION TO JOIN AN ACO

- Board
  - Do you have the right leaders on board?
  - Ability to update strategy
    - Mission
    - Vision
    - Strategies

MAKING THE DECISION TO JOIN AN ACO

Board

Need to understand how this will change the business

- Lines of service

- Initial investment versus long term return

- Changes in the way that care is provided
  - Patient perspective
  - Provider perspective
  - Financial impacts

- This is not the traditional business model

MAKING THE DECISION TO JOIN AN ACO

- C-suite
  - Thick skin
  - Willingness to sacrifice short term results in exchange for long term results
    - Financial results
    - Quality
  - Willingness to put professional reputation on the line
  - Culture
    - Rewards for taking appropriate risks
    - Mistakes will be made

MAKING THE DECISION TO JOIN AN ACO

- Provider Leadership
  - Not always your Chief of Staff
    - Formal versus informal leader
  - Outside the box thinker
    - Health care versus sick care
    - Value versus volume
  - Must be willing to invest time
    - Provider
    - Facility

WHY SHOULD A CAH CONSIDER AN ACO?

Desire to improve the health of the community
- Individuals
- Facility

Understanding the need to decrease the cost of population health

Desire to keep more health care local

Improve employee and provider satisfaction

It is a question of when versus if

IMPROVE THE HEALTH OF THE COMMUNITY – INDIVIDUAL

Early adopters have seen improvement in the health of their patients

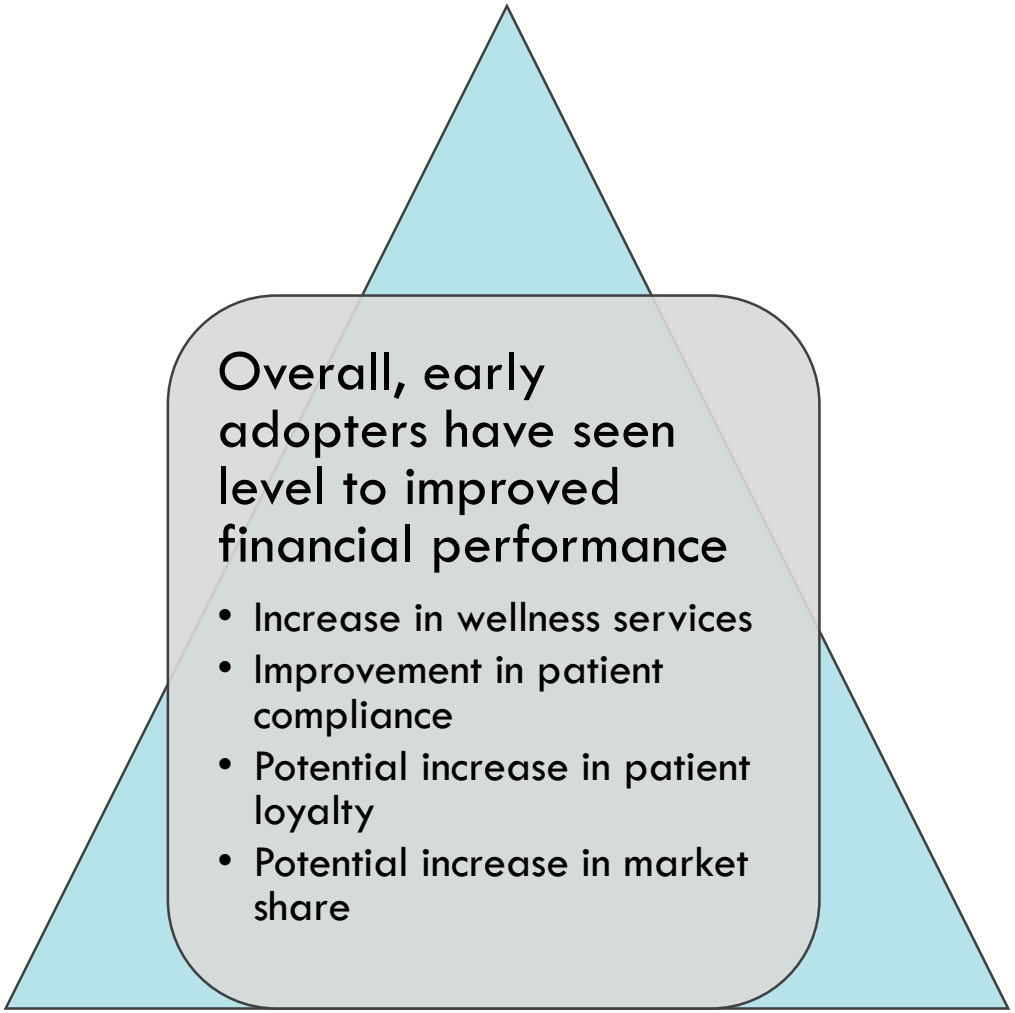
- 5 patients with 250 inpatient days in last year
- Grandmother with uncontrolled diabetes
- Patient with weight gain and becoming non-social

IMPROVE THE HEALTH OF THE COMMUNITY – INDIVIDUAL

Common areas of success

- Diabetes
- Weight Loss
- Mental Health
- Medication compliance

IMPROVE THE HEALTH OF THE COMMUNITY – FACILITY

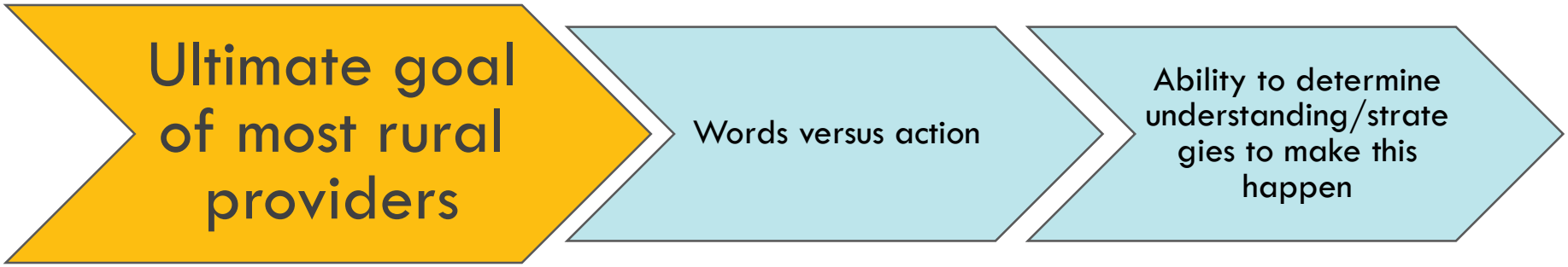


UNDERSTAND THE NEED TO DECREASE THE COST OF POPULATION HEALTH

Facility must understand and be committed to the benefits of decreasing the cost of population health

- May be counterintuitive
- Benefits to society
- Benefits to the local community
- Will become the long-term cost of admission to be a preferred provider

DESIRE TO KEEP MORE HEALTH CARE LOCAL



IMPROVE EMPLOYEE AND PROVIDER SATISFACTION

New methodology to improve satisfaction

- Non-financial factor
- True satisfaction due to improving quality of patient lives
- This is personal

IT IS A QUESTION OF WHEN VERSUS IF

- Early adopters will be able to create the edge
  - Development of strategies
  - Development of relationships to relevant players
    - Physicians
    - Post acute
    - Specialties
    - Etc.
  - Lower level of penalties for mistakes/lessons learned

IT IS ALL ABOUT COORDINATING CARE

Easier said than done

Requires organized teams

- Physician leaders
- Supporting cast of players
  - C-suite
  - Nurses
  - Care coordinators
  - Admissions
  - Marketing
  - Financial analysts

PROCESSES

Nothing changes if you do not change the processes

- Preventative services
- Follow-up

Establishment of process templates

- Annual wellness visits
- Chronic care management
- Transitional care management
- Advanced care planning
- Etc.

PROCESSES

- This is much more difficult than would normally be expected
  - New processes
  - Goal is to reduce cost and/or volumes
    - Not all providers can accept this concept
    - "But I went into health care to take care of sick patients, not health patients"

CARE PLANS

- Care plans created for all high risk patients
  - Locally developed plans
  - Local versus national "cookbooks"
    - Local input
    - Local flexibility

DATA GATHERING AND SHARING

Can only impact access, cost and quality if you have data

- Accuracy
  - Significant challenge
    - Internal data
      - Completeness
      - Missing outside data
    - External data
      - Medicare data files
        - Completeness
        - Ability to mine meaningful information
          - Data versus information versus knowledge
- Timeliness
  - Yearly versus monthly versus weekly versus daily
  - The closer to today the better

DATA GATHERING AND SHARING

Can only impact access, cost and quality if you have data

- Infrastructure
  - Requires systems
- Analysis
  - Requires analysts

DATA GATHERING AND SHARING

- Can only impact access, cost and quality if you have data
  - What can you find?
    - Post acute care
      - Cost per day by provider
      - Cost per day by ownership type
      - Average length of stay by provider
      - Average length of stay by provider type
    - Readmissions
      - By provider
      - By diagnosis

DATA GATHERING AND SHARING

- Can only impact access, cost and quality if you have data
  - What can you find?
    - High frequency patients
      - Emergency room
      - Inpatient hospital
    - High cost patients
      - One timers
      - Chronic
    - High cost providers
      - Discussions
      - Changes in referral patterns

DATA GATHERING AND SHARING

- Can only impact access, cost and quality if you have data
  - What can you find?
    - Market leakage
      - Where do patients go when they do not use local services?
      - By provider
      - By diagnosis
      - Perception versus reality
      - How much would a provider pay for this level of information?

MEDICATION RECONCILIATION

Over medication / competing medication
Medications causing medications
Medications of little or no benefit to the patient
Unknown providers in the care of patients

COORDINATION OF CARE PROVIDES BENEFITS

Increased referrals/orders

Tends to increase local volumes and revenues

- Inpatient may decrease
- Outpatient and clinic increase

Drives the need for improving IT infrastructure

- Internal/external communication
- Should promote long term cost savings

COORDINATION OF CARE PROVIDES BENEFITS

Greater visibility and understanding of impact of referrals
- Quality
- Cost

Promotes increased patient satisfaction
- Perceived quality of care
- Improved health status

Promotes increased market share

WELLNESS PAYS - FINALLY

Starts with 4 main services

- Initial Preventative Physician Examination
- Annual Wellness Visit
- Transitional Care Management
- Chronic Care Management

ANNUAL WELLNESS SERVICES ARE CONFUSING!

It is not a physical!

Significant education is required

- Practitioners
- Staff
- Patients

Must set expectations

Dedicated visit versus dual visit?

Provides for significant data capture

Drives preventative service utilization

WELLNESS PAYS - FINALLY

Leads to:

- Annual Alcohol Misuse Screening
- Face-to-Face Behavioral Counseling for Alcohol Misuse
- Annual Depression Screening
- Cardiovascular Disease Screenings
- Annual, Face-to-Face Intensive Behavioral Therapy for Cardiovascular Disease
- Obesity Screening
- Counseling for Obesity
- Diabetes Outpatient Self-Management Training
- Medical Nutrition Therapy
- Counseling to Prevent Tobacco Use
- Lung Cancer Screening

WELLNESS PAYS - FINALLY

Leads to:

- Ultrasound Screening for Abdominal Aortic Aneurysm
- Health and Behavior Assessments and Interventions
- Self-care or Home Management Training
- Advance Care Planning
- Prostate Cancer Screening
- Screening Pelvic Exam
- Screening Mammography
- Bone Mass Measurements
- Colorectal Cancer Screenings
- Glaucoma Tests

WELLNESS PAYS - FINALLY

Leads to:

- Glaucoma Tests
- Hepatitis C Screening
- HIV Screening
- Sexually Transmitted Infections Screening and Counseling
- Flu Shots
- Hepatitis B Shots
- Pneumococcal Shots

WELLNESS PAYS - FINALLY

Annual Wellness Visit:

- Overtime should help reduce admissions per beneficiary

WELLNESS PAYS - FINALLY

Transitional Care Management

Meant to help patients transition from a hospital to community setting

30 day period from date of discharge

Requirements

- Interactive contact within 2 business days of discharge
- Face-to-face visit
- Non-face-to-face services

Over time should help reduce readmissions per beneficiary

WELLNESS PAYS - FINALLY

Chronic Care Management

Meant to help patients with multiple chronic conditions manage their health

Two or more chronic conditions expected to last at least 12 months or until the death of the patient.

Significant risk of death, acute exacerbation/ decompensation or functional decline

WELLNESS PAYS - FINALLY

Chronic Care Management

Requirements

- Comprehensive care plan
- At least 20 minutes per month

Over time should help reduce

- Hospital admissions
- Emergency Department visits

WELLNESS PAYS - FINALLY

Services tend to be those provided or can be provided by local providers

- New services
- Maintained or increase volumes

WELLNESS PAYS – ALL PROVIDERS

The services and strategies discussed provide opportunities to providers currently not in an ACO

- Less programming requirements
- Less upside opportunity

WELLNESS PAYS - CHALLENGES

Revenue Cycle

- Specific requirements for billing various services
- Requirements vary by provider type
- Importance of Hierarchical Condition Coding (HCC)

Certain provider types encounter greater challenges than others

- Rural Health Clinics
- Federally Qualified Health Centers

All inclusive rate methodology challenges

- Perception
- Reality
- Various strategies

GUIDANCE FROM EXPERTS?

Providers are supplied with significant amounts of guidance from individuals that stayed at a Holiday Inn Express last night

- Consultants
- Neighbors
- Urban legends

Results

- Compliance concerns
- Operational challenges
- Changing guidance from CMS
- Requires constant verification and reverification

UNEXPECTED ITEMS

Access to Home Health and Hospice can be very helpful

- Reduction in post acute care costs

After hours clinics can help reduce Emergency Room Department visits

- Providers looking to extend hours outside of traditional clinic times
- Strategies vary

UNEXPECTED ITEMS

Preferential reporting methodologies and calculations for MACRA/MIPS

Coding really matters

- Hierarchical Condition Categories
- Quality of data for analysis

COMPETING PROGRAMS

Other competing programs provide distraction

- MSSP Track 1
- MSSP Track 1+
- MSSP Track 2
- MSSP Track 3
- CPC+

Need to maintain focus while managing option

SOME PROVIDERS ARE EXPERIENCING SAVINGS

Early results not expected

2015 and 2016 – Many providers shared savings

2017 – Still working on settlement calculations

- Multiple ACOs appear to qualify for some level of shared savings

PLANNING FOR THE FUTURE

- Many providers will complete their third and final year in their current ACO in 2018
  - MSSP ACOs are a three year commitment
- Need to determine next steps
  - Participation
    - Exit
    - Continue with same ACO with existing Partners
    - Continue in a new ACO with new Partners
      - Some from original ACO
      - All
      - Blend
      - High performers/Low performers
      - Geography

PLANNING FOR THE FUTURE

- Need to determine next steps
  - External Resources
    - Enabler
    - Data analytics
    - Financial consultants
    - Etc.
  - Must decide by mid-2018

CLOSING COMMENTS

There are financial opportunities

Great learning opportunities

It is a matter of when, not if

Non-ACO providers can take advantage of many of the benefits without being in an ACO

QUESTIONS?

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THANK YOU!